AHCCCS is Arizona's Medical Assistance Program (Medicaid)

AHCCCS

Referral For Potential Benefits

Customer:	AHCCCS ID:	Customer #:
	Date:	
	Eligibility Specialist: Phone: Fax:	

Referral Information

To qualify for AHCCCS Health Insurance, a person who may be eligible for certain other types of benefits must apply for these benefits.

We have determined that you may be eligible for:

When applying for benefits, take this notice to the appropriate agency and ask the person who accepts your application to complete the bottom portion of this notice and return it to the address shown above no later than: _____.

IF YOU DO NOT APPLY FOR THESE BENEFITS, WE WILL DENY YOUR APPLICATION OR STOP YOUR ONGOING AHCCCS HEALTH INSURANCE

Comments:

Name:	SSN:	Date of Birth:

This section is to be completed by the person who accepts the application. Please check the appropriate box, sign, date and return to the address shown at the top of this letter.

This is to verify that the person named at the top of this letter applied for _____ (Type of Benefit) on _____.

Agency Representative's Signature	Title	Phone Number	Date